**NAME: OGAR REGINA**

**MATRIC NUMBER: 17/MHS02/110**

**NURSING MANAGEMENT OF CARDIAC ARREST**

* Administer medications Such as (Anti- anginals)
* Administer supplemental Oxygen by nasal prongs or face mask as indicated
* Monitor Vital sign(plus,blood pressure)
* Note heart sounds
* Monitor laboratory Status e.g BUN,Creatinine
* Measure cardiac output and other functional parameters
* Monitor closely ECG and Chest x-ray changes
* Monitor electrolyte and nutrition
* Administer IV solution as prescribed
* Encourage rest,semirecumbent in bed or chair, Assist with physical care as indicated.
* Emotional Support Patient/client and family

**NURSING MANAGEMENT OF EPISTAXIS**

Top of Form

* Put on protective gear, including gown, gloves, and face shields. Quickly assess the ABCs (airway, breathing, and circulation) and support them as indicated. Reassure the patient.
* Have the patient sit upright with her head tilted forward, and instruct her to apply direct external digital pressure to the nares with her index finger and thumb. Tell her to breathe through her mouth while she holds firm pressure on the soft flesh of her nose for at least 10 minutes. If bleeding persists, cotton pledgets soaked in a vasoconstrictor and anesthetic will be placed in the anterior nasal cavity, and direct pressure should be applied at both sides of the nose.
* Ensure bedside suction is functioning properly. Provide an emesis basin and tissues. Tell her to spit blood into the basin if necessary. This helps prevent nausea and vomiting and lets you estimate the amount of bleeding.
* Obtain vital signs and SpO2 level, and assess her breath sounds. Administer supplemental oxygen via facemask if needed. Continue to monitor vital signs closely.
* If bleeding is significant, establish vascular access, place the patient on a cardiac monitor, and begin fluid resuscitation with a crystalloid solution, as prescribed. Obtain specimens for blood work, including complete blood cell count and coagulation profile, as prescribed.
* Obtain a focused health history, including previous nosebleeds, other bleeding episodes, easy bruising, and medication use, especially use of aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs), antiplatelet agents, warfarin, and herbal products.
* If bleeding persists, assist in preparing the epistaxis tray and a headlamp. Make sure lighting is adequate. Once the bleeding site is identified, the definitive treatment is cautery (silver nitrate or electrical). If cautery is unsuccessful, nasal packing will be used to apply direct pressure to the bleeding site. During the procedure, reassure the patient, monitor vital signs, and assess for hypoxia.
* After bleeding is controlled, reassess the patient and provide oral care. Keep the patient's mouth moist while the packing is in place.
* If packing is used, especially posterior packing, monitor for respiratory compromise. Tell the patient to report signs and symptoms of infection and teach her about any prescribed antibiotics. If she has posterior packing, she'll be admitted to the hospital. A patient with anterior packing will follow up with an ear, nose, and throat specialist as an outpatient.
* The nasal packing will be left in place for 3 to 5 days. Instruct the patient to avoid exerting herself, forcefully blowing her nose, or bending over. She should also avoid NSAIDs, alcoholic beverages, and smoking for 5 to 7 days. Tell her to apply water-soluble ointment to her lips and nostrils while packing is in place and to use a cool-mist room humidifier. Advise her to take steps to prevent constipation and straining, which increases the risk of bleeding.
* Don't leave the patient unattended during -epistaxis.

**MANAGEMENT OF CARBON MONO OXIDE POISONING**

**ASSESSMENT**

1. **Assess immediately for airway.** If it is due to carbon monoxide smoke inhalation, stridor may be assessed. This is due to the formation of laryngeal edema from thermal injury.
2. **Check for airway obstruction if client is unconscious.** Muscles around air passages may relax if the client turned unconscious due to prolonged exposure or massive poisoning.
3. **Assess for breathing.** Client may manifest respiratory depression (5-10 per minute).

**INITIAL INTERVENTIONS**

* Position to semi-Fowler’s if not contraindicated.
* Secure safety through side rails.
* Administer 100% via face mask. Make sure the mask fits the client’s face to deliver desired amount.
* Monitor for signs on the necessity for intubation.

**FOLLOW-UP ASSESSMENT**

1. Gather incident history from the patient or any person, particularly the type and length of exposure.
2. Determine client’s underlying health status that would cause higher risk, especially for presence of anemia, pulmonary disease, and/or cardiac disease.
3. Monitor vital signs.
* Expect for an elevated respiratory and pulse rates.
* Be alert for altered breathing pattern and episodes of apnea.
1. Recheck for the level of consciousness. Monitor signs of cerebral hypoxia (confusion), for it has the possibility of rapid progression to coma.
2. Assess for other neurologic and other systemic signs like: dizziness, headache, muscular weakness, palpitations
3. Assess for signs of **acute respiratory distress syndrome** (rales and/or wheezes).
4. Monitor ABG (less than 12% is still considered normal)
* Greater than 30% to 40% may be present for severe poisoning.
1. Monitor skin for signs of severity with the perfusion.

**NURSING MANAGEMENT OF FOREIGN BODIES IN THE EYE**

* The nurse should reassure patient appropriately to instill hope
* Place patient in an upright position with adequate lightning
* Assess the affected eye to know the extent of the foreign body. Pull the lower lid down and ask the person to look up. Then hold the upper lid while the person looks down.
* Instruct patient not to poke into the eye or scratch the eye to avoid pushing the object further inside
* The nurse should not attempt to remove the foreign object even if it is visible
* Call the ambulance and refer patient to the hospital where the object can be safely removed